DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11038A (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / ADULT MENTAL HEALTH DAY TREATMENT ATTACHMENT (PA/AMHDTA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization/Adult Mental Health Day Treatment Attachment (PA/AMHDTA) to the Prior Authorization Request Form (PA/RF) and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's name (including last name, first name, and middle initial) exactly as it appears on the recipient's Medicaid identification card.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number exactly as it appears on the recipient's Medicaid identification card.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Requesting / Performing Provider
Enter the name and credentials of the therapist who will be providing treatment.

Element 5 — Requesting / Performing Provider's Medicaid Provider No. (not required)

Element 6 — Telephone Number — Requesting / Performing Provider
Enter the performing provider's telephone number, including area code.

Element 7 — Name — Referring / Prescribing Provider
Enter the name of the provider referring/prescribing treatment.

Element 8 — Referring / Prescribing Provider's Medicaid Provider No.
Enter the referring/prescribing provider's eight-digit provider number.

SECTION III — DOCUMENTATION

Per HFS 101.03(37), Wis. Admin. Code, "Adult Mental Health Day Treatment" is described by the following definition:

> "Day treatment" or "day hospital" means a non-residential program in a medically supervised setting that provides case management, medical care, psychotherapy and other therapies, including recreational, physical, occupational and speech therapies, and follow-up services, to alleviate problems related to mental illness or emotional disturbances.
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> **Note:** Day treatment services are provided by an interdisciplinary team on a routine, continuous basis for a scheduled portion of a 24-hour day and may include structural rehabilitative activities including training in basic living skills, interpersonal skills and problem-solving skills.

Element 9
Enter the number of hours requested per week.

Element 10
Enter the estimated final treatment date.

Element 11
Indicate if the recipient has had previous day treatment at the provider's facility or elsewhere.

Element 12
Describe evaluation, including date(s), tests used, and results.

Element 13
Attach page 1 of the recipient's most recent Functional Assessment Scales. (Functional Assessment must be signed and dated within three months of receipt by Wisconsin Medicaid.)

Element 14
Indicate if the recipient's intellectual functioning is below average.

Element 15
Provide a brief history pertinent to requested services (Include psycho-social history, hospitalization history, family history, living situation history, etc.).

Element 16
Describe progress/status since treatment began or was last authorized, if applicable.

Element 17
Specify overall character of service to be provided.

> **Rehabilitation.** This category is used for all of the target adult mental health day treatment population who may benefit by **intensive** adult mental health day treatment.
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> **Maintenance.** This category is for those recipients, who by diagnosis and history, are suffering from a **chronic mental disorder** as indicated by diagnosis, signs of illness for two or more years, and past intensive adult mental health day treatment that has already been tried for six months or more with no apparent change in functional assessment and/or narrative history. The major goal of treatment here is to **maintain** the individual in the community and prevent hospitalization.
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> **Stabilization.** This category is for those recipients in the target population who decompensate and/or have an acute exacerbation of a chronic condition. The goal in this category is to increase structure, stabilize the recipient, prevent harm to self and/or others, and/or prevent hospitalization. Decompensation would be indicated by a recent hospitalization (i.e., within the last 30 days), and/or other acceptable signs of clear deterioration (in level and course of functioning).

Element 18
Identify measurable treatment goals.

Element 19
Attach a specific schedule of activities, including date, time of day, length of session, and service to be provided.

Element 20
Estimate the recipient's rehabilitation potential for employment (competitive, supported, sheltered, etc.), social interaction, and independent living.

Element 21 — Signature — Recipient or Representative
Enter the signature of the recipient or representative.

Element 22 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/YY format) by the recipient or representative.

Element 23 — Relationship (if representative)
Include relationship to recipient (if a representative signs).

Element 24 — Signature — Prescribing Physician
Enter the signature of the prescribing physician.

Element 25 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/YY format) by the prescribing physician.

Element 26 — Signature — Therapist Providing Treatment
Enter the signature of the therapist providing treatment.

Element 27 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/YY format) by the therapist providing the treatment.

Element 28 — Signature — 51.42 Board Director / Designee
Enter the signature of the 51.42 board director or designee.

Element 29 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/YY format) by the 51.42 board director/designee.